Understanding your Explanation of Benefits (EOB)

Most of us have seen an *explanation of benefits* or EOB, but what does it mean?

After you have visited a doctor, clinic, or hospital, an EOB (the insurance company's written explanation to a claim) tells you and your provider how much of the provider's charges will be paid by the insurance company.

To better understand the EOB take a look at the the claims process. A bill from your health care provider explains the charges for the services you received. A claim is a request by an individual (or his or her provider) to an individual's insurance company to pay for services obtained from a health care professional. A medical provider is rarely, if ever, required to file an insurance claim on a patient's behalf; some do this as a courtesy to patients and to ensure that they are paid in a timely manner.

If your provider is part of a "provider network" (a group of doctors, hospitals and/or other health care providers contracted by insurers to provide services for less than the usual fees) and you have an insurance plan using this network, the provider usually sends your bill to the network administrator to calculate the discount. Insured individuals usually pay less when using an in-network provider, because networks provide services at a lower cost to the insurance companies with which they have contracts. The network then sends the claim to the insurance company.

If your provider is not in a network, the provider may send the bill to you or your insurance company. If you're sent the bill, you'll submit the claim to your insurance carrier.

The insurance company reviews the claim to determine benefits. If another insurance company is involved, they review and coordinate benefits to determine which plan is responsible for the charges. The health insurance company sends you and your provider an EOB, and, when appropriate, your provider also receives a check.

Your EOB may identify:

- The patient and the service provided.
- The amount charged by the provider.
- The amount of the charges that are covered and not covered under your plan.
- The amount paid to your provider.
- The amount you're responsible for.

Remember - an EOB is not a bill, but it explains what was covered by insurance. The provider may bill you separately for any charges you're still responsible for. The example below shows a typical explanation of benefits; however, your particular company may or may not include all of the information shown in this example.

HealthPlan of America, Inc.
P.O. Box 90807
Big City, Texas 39393
(20) Customer Service # 800-555-1212

EXPLANATION OF BENEFITS

(1) Enrollee: John H. Doe
Address: 765 Anywhere Ave.
SmallTown, USA, 98765

Enrollee Plan ID No: 987 654 321 - 01

(2) Patient: Jane P. Doe
(3) Patient #: 123-45-6789

(4) Provider: D. W. DoMore, M.D.
(5) Claim #: 90909090909

(6) Relationship: Spouse

(7) Date Processed: 9/30/2020

Dates of Service (8)	Place of Service (9)	Procedure Code (10)	Charge Amount (11)	Amount Allowed (12)	Not Covered (13)	Benefit Amount (14)	Reason Code (15)	Deductible Amount (16)	Co-Pay (17)	Due From Patient (18)	Payment Amount (19)
8/9/00	2	99283	80.00	80.00					15.00	15.00	
8/9/00	2	30121	75.00		75.00	0.00	55			75.00	0.00
8/9/00	2	36415	20.00	10.00	10.00	80%	44			2.00	8.00
8/9/00	2	80850	40.00	10.00	30.00	80%	44			2.00	8.00

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LEGEND

1. Enrollee Name/ Address: Identifies the policyholder. Usually the name and address of the person who carries the insurance.	**2. Patient:** Identifies the patient. If the patient is the same as the enrollee, this will be indicated by "self".	**3. Patient Number:** An identification number for the patient.	**4. Provider Name:** Identifies the name of the doctor or hospital that is billing for the services.
5. Claim #: The insurance company gives a number to identify the claim in their computer system.	**6. Relationship:** Identifies the relationship of the patient to the Enrollee.	**7. Date Processed:** The date the claim is processed.	**8. Dates of Service:** The date the patient received medical care.
9. Place of Service: Lists the location where the patient received the service. This is important as some services are only covered in specific locations.	**10. CPT Code:** Identifies the service performed. This code is universal and determines the payment amount.	**11. Charge Amount:** Amount charged by the provider.	**12. Allowed Amount:** Amount determined by a preset schedule of "usual and customary" (UCR) charges.
13. Not Covered: Amount of the charge not covered by insurance. Usually the patient is responsible to pay this amount.	**14. Benefit Amount:** The percentage at which the amount covered will be paid. The percentage paid will be determined by the schedule of benefits.	**15. Reason Code: A**n explanation of why a service has been has denied, or why an amount is not covered. There is usually a legend that identifies these codes.	**16. Deductible:** The amount the patient must pay prior to having benefits paid. Amounts that are not covered are not applied to the deductible. Deductibles may be required for both participating and not participating services.
17. Co-Pay: A minimal amount required from the patient when seeking services from a provider. Usually the patient is only responsible for copayments at a participating provider.	**18. Due from Patient:** The amount the patient is responsible to pay the provider. This generally includes the co-insurance and deductible.	**19. Payment Amount:** The amount the insurance paid to the provider.	**20. Customer Service:** The phone number used to contact customer service.